STATE OF CALIFORNIA
DECISION OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD

JEFFREY REESE, Charging Party, v. COUNTY OF SANTA CLARA, Respondent.	Case No. SF-CE-1329-M PERB Decision No. 2629-M February 27, 2019

Appearances: Wylie, McBride, Platten & Renner by Christopher E. Platten, Attorney, for Jeffrey Reese; James R. Williams, County Counsel, and Nancy J. Clark, Deputy County Counsel, for County of Santa Clara.

Before Banks, Shiners, and Krantz, Members.

DECISION

KRANTZ, Member: This case is before the Public Employment Relations Board (PERB or Board) on exceptions by Respondent County of Santa Clara (County) to the attached proposed decision by an administrative law judge (ALJ). The ALJ concluded that the County discriminated against Charging Party Jeffrey Reese (Reese), chief of urology at Santa Clara Valley Medical Center (SCVMC), by removing his administrative duties because of actions he took on behalf of his bargaining unit's exclusive representative, the Valley Physicians Group (VPG). The ALJ found that the County thereby violated the Meyers-Milias-Brown Act (MMBA)[1] and PERB Regulations.[2] As a remedy, the ALJ ordered the County to, among other things, restore all duties that it had unlawfully removed from Reese's chief of urology position.

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[1] The MMBA is codified at Government Code section 3500 et seq. Unless otherwise indicated, all statutory references herein are to the Government Code.

[2] PERB Regulations are codified at California Code of Regulations, title 8, section 31001 et seq.

The County excepts to the ALJ's finding that it removed Reese's duties because he exercised protected rights. More specifically, the County asserts that the ALJ applied an improper standard to conclude that a causal nexus existed between Reese's protected activity and the reassignment of some of Reese's duties, and that the ALJ failed to consider the County's affirmative defense that it would have taken the same actions absent Reese's protected activity. Reese disputes these contentions and urges us to affirm the proposed decision.

We have reviewed the record in this matter and considered the parties' arguments in light of applicable law. We conclude that the record supports the ALJ's proposed decision, and we adopt it as the decision of the Board itself, subject to and as clarified by the following discussion of the County's exceptions.

BACKGROUND

The ALJ's procedural history and factual findings can be found in the attached proposed decision. We provide only a brief summary here to give context to our discussion of the County's exceptions.

Reese, a urologist, began working for the County in 1990. In 1996, he began serving as the division chief of urology in the department of surgery at SCVMC, the County's hospital.

At the time of trial, SCVMC had 15 departments. Many departments, including surgery, are headed by a chair. The departments, in turn, are composed of divisions, each with a chief who reports to the chair. At all relevant times, Gregg Adams (Adams), a trauma surgeon, served as chair of the surgery department. Adams testified that chairs select and remove division chiefs. Under the approved rules and procedures of the surgery department, the division chief is "responsible for all administrative, research, clinical, quality assessment, [and] educational

activities" within the clinical division. A division chief must, as a minimum job requirement, have certification from the Medical Board of California (Medical Board).[3]

Jeffrey Arnold (Arnold) became SCVMC's chief medical officer in 2012. The chief medical officer is a physician responsible for managing the provider staff, hiring and firing physicians, and determining their salaries. Physicians, including Reese, are employed at-will.

In 2010, VPG became the exclusive representative for the County's physician bargaining unit. VPG and the County negotiated their first memorandum of understanding (MOU) with a term of November 28, 2011, through November 24, 2013. Following the first MOU, VPG representatives participated in a joint labor-management committee focusing on implementation of the negotiated terms of the agreement. Reese was a member of this "implementation committee" between November 2011 and April 2012. Reese joined VPG's bargaining team in Fall 2013 for successor MOU negotiations, and he was the only team member who had served on the implementation committee. The negotiations extended over three years. Arnold participated as a member of the County's bargaining team from late 2013 through late 2014. The negotiations around issues of workload and compensation were tense. For example, Arnold indicated during bargaining that physician workloads needed to increase. In contrast, members of the VPG bargaining team, including Reese, expressed their concerns related to patient safety and service quality if physician workloads were to become excessive.

In October 2013, Reese sent Arnold an e-mail in which he raised staffing issues and conveyed his idea for eventually transitioning out of his chief position. Reese explained in the e-mail that he had suffered back spasms as a result of performing lengthy oncologic surgeries. This prompted him to consider the need to scale back his workload over the "next few years,"

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[3] Physicians become Medical Board-certified through a rigorous examination process that includes submission of patient records as well as oral and written examination.

while remaining division chief over that period of time. Reese's e-mail also explained that the existing urology staff was "maxing out" on its workload. Arnold did not respond for four months to Reese's request to meet and discuss the issues he raised, and did so only when Reese renewed his request.

One year later, in 2014, Reese counseled one of the five urologists on staff, Dr. R., for allegedly attending guitar classes during his administrative time. Dr. R. then left with only one month's notice. Reese assessed the division's caseload and asked Arnold to replace Dr. R and also hire one additional clinician. Arnold ultimately agreed to the two positions, but there were delays and resulting backlogs.

Meanwhile, Arnold believed the hospital was inefficient and unlikely to survive in a competitive environment. In 2014, approximately 50,000 new patients were eligible to be served by the County health system, including those becoming eligible for Medi-Cal and private insurance under Covered California as a result of the Affordable Care Act. There is no evidence that the hospital added staff to respond to the anticipated influx of new patients. Arnold had made it known to VPG at the bargaining table that the hospital would be moving to a "Costco"-type service delivery model where workload would be increased over time.

Without consulting Reese or Adams, Arnold vetted a urologist, Dr. Tin Ngo (Ngo), for hire. Arnold offered him a position in March 2015 but did not tell Reese.[4] Ngo commenced employment in June. In early 2015, several months before Ngo officially began work, Arnold told Adams that Reese was not the "correct" person to be chief. Sometime after Ngo was identified as a potential new hire, Arnold proposed to Adams the idea of having Ngo replace Reese as division chief. Then, in March, Adams informed Reese that Arnold had decided Ngo

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[4] Hereafter, all dates refer to 2015, unless otherwise indicated.

would replace him as division chief. Reese testified he was stunned to hear this for a number of reasons, including the fact that Ngo did not have Reese's experience or qualifications. Among other issues, Ngo, unlike Reese, was not Medical Board-certified.

When Reese asked Adams for an explanation of Arnold's decision, Adams said the decision was not based on logic but rather on Arnold's personal view of Reese. Adams also told Reese not to contact Arnold at this point because Reese was "getting under [Arnold's] skin."

While Adams agreed with Arnold that Reese's strengths were not on the "operational" side, Adams objected to Arnold's plan that Ngo replace Reese as division chief for two reasons. First, it would violate his department's rules, which required a division chief to be Medical Board-certified. Second, it was premature. Adams understood Reese's intention to identify and groom a successor but foresaw him stepping down in a couple of years, after his successor—whoever that might be—had established him or herself and been vetted by the division.

Reese conveyed to Adams that he suspected retaliation for his activities on behalf of VPG, and Adams relayed Reese's suspicions to Arnold. Adams believed Arnold's plan could be viewed as retaliatory. Arnold denied that he was retaliating against Reese, though he told Adams that he planned for Ngo to assume leadership on "day one." Ngo, however, was willing to defer until August 1.

On July 22, Arnold informed Adams in an e-mail that he was proposing to have Ngo named "interim chief" as of August 3. Adams rejected Arnold's proposal because Ngo was not yet Medical Board-certified. Arnold then decided to install Ngo as a "medical director," giving Ngo most of Reese's authority as chief. Prior to the events described above, medical directors had been appointed to supplement the work of chiefs in areas where there were challenging operational issues. Adams testified that even though Ngo was not to start out as division chief,

Ngo told him he had the authority from Arnold to make changes in the urology division. Arnold had not notified Adams of this authority. Adams relayed the message to Reese, and told Reese he would have to step down promptly. Adams testified that he agreed a leadership change was needed eventually but that he disagreed with the timing.

Sometime in August, Arnold increased Ngo's pay to equal Reese's. On August 31, Arnold announced that Ngo had been appointed medical director of urology effective September 1. Ngo had informed urology staff of the news shortly before then. After Arnold's announcement, Ngo informed the staff that Reese would remain division chief, but without responsibility for operational matters. Reese did not suffer a loss of pay, but 90 percent of his leadership duties were removed.

DISCUSSION

Although the Board reviews exceptions to a proposed decision de novo, to the extent that a proposed decision adequately addresses issues raised by certain exceptions, the Board need not further analyze those exceptions. (*City of San Ramon* (2018) PERB Decision No. 2571-M, p. 5.) The Board also need not address alleged errors that would not impact the outcome.[5] (*Ibid*.) To the extent an ALJ assesses credibility based upon observing a witness in

[5] The County excepts to the ALJ's reference in certain footnotes to "corroborative source material" publically available through a website search. The ALJ did not rely on these materials—mainly reports from non-profit and government agencies and scholarly journals—as record evidence. The ALJ apparently relied on them to learn about or explain complicated or unfamiliar concepts, much as a judge might in other instances rely on and even cite to topical law review articles. Indeed, the County itself apparently recognized that the ALJ could benefit from reference to such material, as in its post-hearing brief the County provided the web citation to one of the very articles about which it now excepts. In any event, we need not decide whether it was appropriate for the ALJ to cite to or take administrative notice of these materials, as the ALJ's dispositive findings are adequately supported without reference to them.

the act of testifying, we defer to such assessments unless the record warrants overturning them. (*Los Angeles Unified School District* (2014) PERB Decision No. 2390, p. 12.)

To demonstrate that an employer has discriminated or retaliated against an employee in violation of MMBA sections 3506 and 3506.5 and PERB Regulation 32603, subdivision (a), the charging party must show that: (1) the employee exercised rights under MMBA; (2) the employer had knowledge of the exercise of those rights; (3) the employer took adverse action against the employee; and (4) the employer took the action *because of* the exercise of those rights. (*Novato Unified School District* (1982) PERB Decision No. 210, pp. 6-8 (*Novato*); *County of Yolo* (2009) PERB Decision No. 2020-M, p. 10 (*Yolo*).) If the charging party establishes a prima facie case that protected activity was a motivating factor for the adverse action, the burden shifts to the employer to demonstrate that it would have taken the same action even in the absence of the protected conduct. (*Novato, supra*, PERB Decision No. 210, p. 14; *Yolo*, *supra*, PERB Decision No. 2020-M, p. 17.)

While the County acknowledges that the proposed decision correctly states the well-established *Novato* standard, it contends the ALJ did not correctly apply the standard when assessing Arnold's motivation for removing most of Reese's authority as division chief, and did not consider the County's affirmative defense that Arnold would have taken the same action notwithstanding Reese's protected activities. The County claims the ALJ held Reese to a "lower standard of proof" for demonstrating unlawful motive, and the County further contends that the ALJ should have imposed "a *higher* burden of proof" on Reese because he was an at-will employee. We turn now to those arguments.[6]

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[6] The County does not dispute that beginning in 2012, Reese exercised rights guaranteed by the MMBA by representing VPG on the implementation committee and bargaining team, as well as by expressing his views about physician workload, staff, changes

A. Framework for Assessing Motivation

The charging party has the initial burden of demonstrating the "because of" element, that is, a causal connection or "nexus" between the adverse action and the protected conduct. (MMBA, § 3506.5; PERB Regulation 32603, subd. (a); *Novato*, *supra*, PERB Decision No. 210, pp. 5-6.) Because "retaliatory conduct is inherently volitional in nature," where it is alleged that the employer has acted in reprisal against employees for participation in protected activity, evidence of unlawful motive is the specific nexus required to establish a prima facie case. (*Id.* at p. 6.)

PERB generally analyzes allegations of employer reprisal and discrimination under two lines of cases, which can be distinguished primarily by the manner in which they permit the charging party to prove nexus. (*City of Yuba City* (2018) PERB Decision No. 2603-M, p. 10.) Under *Campbell Municipal Employees Association v. City of Campbell* (1982) 131 Cal.App.3d 416, 423-424 (*Campbell*), a charging party may establish "discrimination in its simplest form" via evidence of "employer conduct that is facially or inherently discriminatory, such that the employer's unlawful motive can be inferred without specific evidence." (*Los Angeles County Superior Court* (2018) PERB Decision No. 2566-C, p. 14 (*LA Superior Court*).) In the absence of evidence sufficient to trigger the *Campbell* standard, we apply the *Novato* analysis of nexus factors. (*LA Superior Court*, *supra*, PERB Decision No. 2566-C, pp. 14-15.) The *Novato* factors

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to pager calls, and other issues. The County also does not dispute that it had knowledge of Reese's protected activities. Although the County argued before the ALJ that removing Reese's administrative duties did not constitute adverse action, it did not except to the ALJ's legal conclusion to the contrary. Because neither party excepted to the legal conclusions that: (1) Reese exercised rights under the MMBA; (2) the County had knowledge of his exercise of those rights; and (3) it took adverse action against him, these conclusions are not before the Board on appeal. Accordingly, the ALJ's conclusions regarding these issues in the attached proposed decision are binding only on the parties. (PERB Regs. 32215, 32300, subd. (c); *City of Torrance* (2009) PERB Decision No. 2004, p. 12.)

have undoubtedly become the primary avenue for proving discrimination or retaliation allegations, and we rely on them where, as here, the employer's conduct is not inherently discriminatory. In this case, neither party argued that the adverse action was discriminatory on its face under *Campbell* and its progeny; rather, both parties agreed that the *Novato* factors frame the correct inquiry here.

B. The *Novato* Factors and Their Application Here

Under *Novato*, a charging party may prove unlawful motive, intent, or purpose through direct or circumstantial evidence, including evidence which tends to show that an employer's proffered justification for its action was not its true motive or purpose. (*Novato*, *supra*, PERB Decision No. 210, p. 6.) Circumstantial evidence, including evidence under one or more of the nexus factors borrowed from *Wright Line*[7] and other private-sector authority, can be equally as probative as direct evidence. (*LA Superior Court*, *supra*, PERB Decision No. 2566-C, p. 20, fn. 13.) "[D]irect proof of motivation is rarely possible, since motivation is a state of mind which may be known only to the actor. Thus . . . unlawful motive can be established by circumstantial evidence and inferred from the record as a whole." (*Novato*, *supra*, PERB Decision No. 210, p. 6.)

While we consider all relevant facts and circumstances in assessing an employer's motivation, we have identified the following factors as being the most common means of establishing a discriminatory motive, intent, or purpose: (1) timing of the employer's adverse action in close temporal proximity to the employee's protected conduct is an important factor; (2) the employer's disparate treatment of the employee; (3) the employer's departure from established procedures and standards when dealing with the employee; (4) the employer's inconsistent or contradictory justifications for its actions; (5) the employer's cursory investigation of the employee's misconduct; (6) the employer's failure to offer the employee

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[7] *NLRB v. Wright Line, a Div. of Wright Line, Inc.* (1st Cir. 1981) 662 F.2d 899 (*Wright Line*).

justification at the time it took action or the offering of exaggerated, vague or ambiguous reasons; (7) employer animosity towards union activists; and (8) any other facts that might demonstrate the employer's unlawful motive. (*Yolo*, *supra*, PERB Decision No. 2020-M, pp. 12-13; *Novato*, *supra*, PERB Decision No. 210, pp. 6-7.)

The County asserts that in applying *Novato*, the ALJ made two principal errors of law. First, the County asserts that the ALJ improperly "determined that the decision to remove Reese's operational/managerial duties, in and of itself, was proof of unlawful motive[,]" in essence reducing or even eliminating Reese's burden of proving nexus and instead finding nexus "as a matter of law." In support of this assertion, the County argues the ALJ wrongly believed that "heightened scrutiny" applies where, as here, "the decisionmaker's personal and professional interests stand in direct opposition to protected organizational interests sought to be advanced by the charging party." (Proposed decision, p. 30.) Second, citing *County of Santa Clara* (2012) PERB Decision No. 2267-M, the County argues the ALJ erred by failing to impose a higher burden of proof on Reese, an at-will employee.

We have independently reviewed the record and find that it adequately supports the proposed decision. However, the County raises important issues likely to recur in the future. As a result, we supplement the proposed decision by clarifying that the present circumstances warrant neither heightened scrutiny of the County's arguments nor a higher burden of proof on Reese.

To begin with, we do not read the proposed decision as permitting an adverse action, in and of itself, to establish an employer's unlawful motive. Contrary to the County's exception, in stating "[a]n adverse action that substantially advances the prerogatives of management while threatening the interests of the union is evidence of unlawful animus," the ALJ did not apply a new legal standard. (See generally proposed decision, p. 30.) Rather, the ALJ recognized that

when an adverse action advances a management interest—e.g., eliminating opposition to a management objective affecting the terms and conditions of employment—this fact may indicate the adverse action was motivated by the employer's desire to further that interest. (See *Yolo*, *supra*, PERB Decision No. 2020-M, p. 13 [the nexus analysis may consider "any other facts that might demonstrate the employer's unlawful motive"].)

We thus agree with the ALJ that "[c]ontext is always relevant" in assessing motive. (Proposed decision, p. 30.) In the factual context here, it was significant that Reese first contested Arnold's stated interest in increasing the physicians' workloads during successor MOU bargaining and thereafter continued to advocate for additional staffing to ease the urology staff's workload. Removing Reese's operational duties limited his ability to oppose Arnold's plan to increase physicians' workload consistent with his preferred service delivery model. While an employee and a supervisor could have personal or professional clashes that are in no way related to protected conduct—in which case we would not find a supervisor's motivation to be unlawful under the MMBA, absent other evidence—in this case Arnold's managerial concerns about Reese were directly related to the very matters he had raised in the course of his protected conduct. Moreover, other nexus factors similarly point toward unlawful discrimination.[8] Thus, we have not excused Reese from carrying his burden of proving nexus.

Relatedly, the County contends the ALJ failed to consider its affirmative defense that it would have taken the same action even in the absence of Reese's protected conduct. Although

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[8] The most significant factors include those discussed in the attached proposed decision at pp. 33-40. (See proposed decision, *post*, pp. 33-34 [timing suggests unlawful motivation], p. 36 [investigation of issues related to leadership in urology was superficial], p. 37 [justification for removing Reese's duties was exaggerated and not supported by credible evidence of deficiencies on Reese's part or failed attempts to correct deficiencies brought to his attention], pp. 37-39 [exaggerated and inconsistent reason for taking adverse action], p. 39 [deviation from the custom and practice regarding appointment of division chiefs], and pp. 39-40 [inference of animus toward union activists based on pattern of avoiding Reese's invitations for meetings].)

the proposed decision does not contain a separate subject heading entitled "Affirmative Defense," the ALJ considered the County's asserted justification for removing the administrative duties from Reese. We agree that the evidence did not support the County's claim regarding the urgency of bringing Ngo on as medical director and transferring substantial authority from Reese to Ngo. (See proposed decision, pp. 34-38.) We thus find that the ALJ appropriately considered the County's evidence and determined that it did not support finding an alternative non-retaliatory reason for taking the adverse action. (See *Novato*, *supra*, PERB Decision No. 210, p. 14 ["After all the evidence is in, it is a question of the sufficiency of the proof proffered by the various parties. The shifting burden merely requires the employer to make what is actually an affirmative defense to the prima facie case of wrongful motive"].)

We also reject the County's argument that the ALJ was required to hold Reese to a higher standard of proof in establishing a prima facie discrimination or retaliation case because Reese was an at-will employee and County management had unfettered discretion in vesting authority in division chiefs and medical directors. We dispensed with this argument in *Los Angeles Unified School District* (2016) PERB Decision No. 2479 (*Los Angeles*), wherein we held that the elements of a prima facie case under *Novato* remain the same "regardless of the employee's at-will or similar status or the procedural protections to which the employee may or may not be entitled to in a different forum," and that "once the employee establishes a prima facie case, the employer's *Novato* defensive legal burden attaches, regardless of the status of the employee." (*Id.* at p. 14.) In *Los Angeles*, we disavowed the suggestion in *County of Santa Clara* that, with respect to a probationary employee, "[a]n employee alleging discrimination who is subject to dismissal without cause bears a heavier burden in overcoming the employer's case for non-discriminatory motive." (*Los Angeles*, *supra*, PERB Decision No. 2479, p. 14, quoting *County of Santa Clara*, *supra*, PERB Decision No. 2267-M, adopting ALJ proposed decision, at p. 21.)

Finally, our holding is consistent with an important principle: even when an employer has a managerial, statutory, or contractual right to take an employment action, its decision to act cannot be based on an unlawful motive, intent, or purpose. (*County of Lassen* (2018) PERB Decision No. 2612-M, p. 6; *Berkeley Unified School District* (2003) PERB Decision No. 1538, pp. 4-5.)

In sum, the instant facts provide no cause to raise or lower the level of proof required of any party under *Novato*, and we find Reese has proven that the County's removal or weakening of certain division chief duties was an adverse action imposed because of his protected activity, in violation of MMBA sections 3506 and 3606.5, and PERB Regulation 32603, subdivision (a).

ORDER

Upon the foregoing findings of fact and conclusions of law, and the entire record in this case, it has been found that the County of Santa Clara (County) violated the Meyers-Milias-Brown Act by discriminating against Jeffrey Reese (Reese) in violation of Government Code sections 3506 and 3506.5, and Public Employment Relations Board (PERB or Board) Regulation 32603, subdivision (a) (Cal. Code of Regs., tit. 8, sec. 31001 et seq.).

Pursuant to section 3509, subdivision (a), of the Government Code, it hereby is ORDERED that the County, its governing board, and its representatives shall:

A. CEASE AND DESIST FROM:

Discriminating against Reese because of his protected activities.

B. TAKE THE FOLLOWING AFFIRMATIVE ACTIONS DESIGNED TO EFFECTUATE THE POLICIES OF THE ACT:

1. Within ten (10) workdays following the date this decision is no longer subject to appeal, offer Reese the position of chief of the urology division as that position existed prior to September 1, 2015, including all duties and responsibilities transferred to the medical director of the division.

2. Within ten (10) workdays following the date this decision is no longer subject to appeal, post copies of the Notice, attached hereto as an appendix, at all work locations where notices to employees in the bargaining unit customarily are posted. The Notice must be signed by an authorized agent of the County, indicating that it will comply with the terms of this Order. Such posting shall be maintained for a period of thirty (30) consecutive workdays. The Notice shall also be posted by electronic message, intranet, internet site, and other electronic means customarily used by the County to communicate with employees in the bargaining unit. Reasonable steps shall be taken to ensure that the Notice is not reduced in size, altered, defaced or covered with any other material.

3. Within thirty (30) workdays following the date this decision is no longer subject to appeal, notify the General Counsel of PERB, or his or her designee, in writing of the steps taken to comply with the terms of this Order. The County shall continue to report in writing to the General Counsel, or his or her designee, periodically thereafter as directed. All reports regarding compliance with this Order shall be served concurrently on the charging party.

Member Banks and Shiners joined in this Decision.

APPENDIX

NOTICE TO EMPLOYEES
POSTED BY ORDER OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD
An Agency of the State of California

After a hearing in Unfair Practice Case No. SF-CE-1329-M, *Jeffrey Reese v. County of Santa Clara*, in which the parties had the right to participate, it has been found that the County of Santa Clara violated the Meyers-Milias-Brown Act (Act), Government Code sections 3506 and 3506.5, and PERB Regulation 32603, subdivision (a) (Cal. Code of Regs., tit. 8, sec. 31001, et seq.) by discriminating against Jeffrey Reese (Reese) for his protected activities.

As a result of these findings, we have been ordered to post this Notice and we will:

A. CEASE AND DESIST FROM:

Discriminating against Reese because of his protected activities.

B. TAKE THE FOLLOWING AFFIRMATIVE ACTIONS DESIGNED TO EFFECTUATE THE POLICIES OF THE ACT:

Offer Reese the position of chief of the urology division as that position existed prior to September 1, 2015, including all duties and responsibilities transferred to the medical director of the division.

Dated: ______________________ COUNTY OF SANTA CLARA

By: ________________________________
Authorized Agent

THIS IS AN OFFICIAL NOTICE. IT MUST REMAIN POSTED FOR AT LEAST THIRTY (30) CONSECUTIVE WORKDAYS FROM THE DATE OF POSTING AND MUST NOT BE REDUCED IN SIZE, DEFACED, ALTERED OR COVERED WITH ANY OTHER MATERIAL.

STATE OF CALIFORNIA
PUBLIC EMPLOYMENT RELATIONS BOARD

JEFFREY REESE, M.D., Charging Party, v. COUNTY OF SANTA CLARA, Respondent.	UNFAIR PRACTICE CASE NO. SF-CE-1329-M PROPOSED DECISION (November 30, 2017)

Appearances: Wylie, McBride, Platten & Renner, by Christopher E. Platten, Attorney for Jeffrey Reese, M.D.; Office of the County Counsel, by Nancy J. Clark, Deputy County Counsel for County of Santa Clara.

Before Donn Ginoza, Administrative Law Judge.

PROCEDURAL HISTORY

Dr. Jeffrey Reese initiated this action by filing an unfair practice charge against the County of Santa Clara (County) under the Meyers-Milias-Brown Act (MMBA or Act)[1] on July 27, 2015. On February 3, 2016, the Office of the General Counsel of the Public Employment Relations Board (PERB or Board) issued a complaint alleging that the County discriminated against Reese because of activities on behalf of his bargaining unit's exclusive representative, (advocacy related to scheduling, staffing, wages, and other matters) by "removing" him from his position as chief of urology. This conduct is alleged to violate sections 3506, 3506.5, and 3509(b) of the Act and PERB Regulation 32603(a).[2]

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[1] The MMBA is codified at Government Code section 3500 et seq. Hereafter all statutory references are to the Government Code unless otherwise indicated.

[2] PERB Regulations are codified at California Code of Regulations, title 8, section 31001, et seq.

On February 25, 2016, the County filed its answer to the complaint denying the material allegations and raising a number of affirmative defenses.

On March 23, 2016, an informal settlement conference was held but the matter was not resolved.

On April 5, 6, and 7, 2017, a formal hearing was conducted in Oakland.

On September 28, 2017, the matter was submitted for decision with the filing of post-hearing briefs.

FINDINGS OF FACT

Dr. Reese is an employee within the meaning of section 3501(d). The County is a public agency within the meaning of section 3501(c). Valley Physicians Group (VPG) is the exclusive representative for the County's bargaining unit composed of physicians and dentists.

The County is a safety net health provider operating through the Santa Clara Valley Health and Hospital System (SCVHHS). (Welf. & Inst. Code, sec. 17000.) SCVHHS comprises a primary care and outpatient clinic network and a level one trauma center hospital, Santa Clara Valley Medical Center (SCVMC). In addition to providing health care to the indigent uninsured, SCVHHS operates a Medi-Cal managed care plan and a commercial managed care plan available to County employees. The system employs 800 physicians that include a number outside of the bargaining unit. The SCVMC operates a residency program in collaboration with Stanford University, with the latter providing the didactic portion of training.

VPG was certified as the exclusive representative in 2010. It negotiated its first memorandum of understanding (MOU) with a term of November 28, 2011, through November 24, 2013. During successor agreement negotiations the parties extended the expired MOU

through March 29, 2015. A successor MOU commenced on May 16, 2016.[3] The MOU prohibits County discrimination against employees participating in VPG and provides for binding arbitration of grievances. Aside from base pay guarantees and prohibitions against reductions, the first MOU achieved no improvements in compensation and allowed salary decisions to remain within the County's discretion. The MOU defines full-time duty as 2080 hours per year. The MOU defines business hours, weekday night hours, and weekend hours, and provides differentials for regular non-business hour duty. The MOU acknowledges the professional nature of the work by permitting assigned duties to be completed outside of regular shifts without additional compensation.

The SCVMC's 15 departments include such practice groups as medicine, emergency medicine, pediatrics, family medicine, and surgery. The departments, especially the larger ones like surgery, are headed by a chair. The departments in turn are composed of divisions, each with a leader called the chief, who reports to the chair. Dr. Gregg Adams, a trauma surgeon, is the chair of surgery department. Adams testified that chairs select and remove their division chiefs.

As required by California law, the SCVMC has established an independently governed medical staff organization for credentialing, discipline, hospital privileges, utilization review, and quality assurance. The medical staff organization must adopt bylaws for its governance activities. SVCMC's Medical Staff's Executive Committee (MEC) is composed of the chairs of the departments. The MEC works with SCVMC's executive leadership on operational issues, though the focus of the MEC is on the highest possible quality of care. The chief medical officer is a voting member of the MEC. The chief medical officer's "authority to

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[3] At the time of the hearing the County had not published the new agreement.

perform functions on behalf of the medical staff or directly affect the performance or activities of the Medical Staff" is subject to approval of the MEC. The MEC bylaws describe a division chief as being responsible for the "clinical administrative, quality improvement, risk management, utilization management, and collegial and education functions within the designated clinical division." The bylaws provide for promulgation of rules and procedures by the departments. "Rules" under the bylaws include departmental rules. Some of the larger departments, including surgery,[4] have their own rules of procedure that regulate matters within the department. The MEC has approved rules and procedures for the surgery department. These rules state that the division chief is "responsible for all administrative, research, clinical, quality assessment, educational activities," and require that the chief be board certified.[5] Adams described the medical staff bylaws as a "firewall between the needs of administration and the quality of medical care being delivered."

SCVMC is led administratively by a chief executive officer, Paul Lorenz, who reports to the County's governing board. The chief medical officer is a physician responsible for managing the provider staff. The chief medical officer has a special responsibility in terms of employer-employee relations as a result of hiring and firing physicians and determining their salaries. Physicians are employed at-will. Dr. Jeffrey Arnold became the chief medical officer in 2012. Arnold reports to Lorenz.

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[4] The medicine department is a larger department with numerous subspecialties, such as cardiology, hematology, endocrinology, and typically have larger divisions than surgery due to larger patient populations.

[5] Board certification in specialties is obtained through a rigorous examination process that includes submission of patient records as well as oral and written examination.

Arnold was hired soon after passage of the Patient Protection and Affordable Care Act (PPACA). The PPACA yielded as many as 50,000 newly insured patients for SCVHHS as a result of the relaxing eligibility requirements for Medi-Cal patients participating through the County's Medi-Cal managed care plan and patients acquiring insurance from private plans through Covered California. Health care reform, which is an extension of a long history of cost-containment challenges for the health care industry, has led to advocacy of new goals. As interpreted by Dr. Arnold these include: (1) more effective patient care that moves away from patient-centered care and "individual autonomous doctors" in favor of "team leaders"; (2) improving value and moving toward quantification of value for dollar spent, and (3) improved patient satisfaction.[6] Within the region served by the County, there were five health systems with hospitals, none of which is "dominant." Kaiser and Stanford were expanding and interested in acquiring Medi-Cal managed care patients. Newly eligible Medi-Cal and Covered California participants began entering the SCVHHS in 2014.

Arnold had come from chairing the SCVMC emergency department which he viewed as inefficient due to its teaching activities. Physicians were changing jobs, making recruitment a challenge. Some were leaving systems like the County due to the implementation of

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[6] The non-profit Institute for Healthcare Improvement describes the benefits of its Triple Aim as follows: "Organizations and communities that attain the Triple Aim will have healthier populations, in part because of new designs that better identify problems and solutions further upstream and outside of acute health care. Patients can expect less complex and much more coordinated care and the burden of illness will decrease. Importantly, stabilizing or reducing the per capita cost of care for populations will give businesses the opportunity to be more competitive, lessen the pressure on publicly funded health care budgets, and provide communities with more flexibility to invest in activities, such as schools and the lived environment, that increase the vitality and economic wellbeing of their inhabitants." (http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.) (Hereafter, website locations for corroborative source material are omitted, but may be accessed through a Google search.)

electronic medical records (EMR) in 2013.[7] Others were retiring from the County, starting their CalPERS pensions, and resuming work in the private sector. As a "solution to workforce needs," Arnold favored hiring physicians with multiple skill sets, which he described as being able to practice to the "top of their license." Arnold also sought to promote growth and development of the staff as professionals.

As it related to his specific responsibilities, Arnold was concerned with lack of accountability on the part of physicians based on data being gathered and addressing it through leadership development. Arnold felt there was potential for abuse because of schedules containing "white spaces" where it was unclear whether the time was being used patient care. Arnold described his principal goal as: "Trying to transparently get data into the hands of people, so they could get feedback about what they were doing and ask questions about what that meant, and to try to get process improvement going where we could."[8] The major initiative as it related to the surgery department was led by Dr. Aradhana Ghosh.

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[7] EMR systems have changed the way in which physicians practice medicine. While there are many efficiencies achieved, including potentially improved patient outcomes, they result in more reports to review and communication with patients and others as a result of email.

[8] A 2014-2015 civil grand jury report concerning the performance of the SCVMC indicates that the grand jury has been preoccupied with the trend of escalating subsidies from the general fund beginning in the 1980s. Indicating concessions to the grand jury, the report reveals that the County created an "enterprise" fund in 2015 to "pay for the operation and maintenance of facilities and services which *are predominantly self-supporting* by charges to the users of the services." (2014-2015 Santa Clara County Civil Grand Jury Report, "Santa Clara Valley Medical Center Community Update on Performance," p. 1, italics added.) The grand jury's 2012 recommendations included requiring that SCVMC leadership run the center as a "business," require leadership to use hospital generated data to make "appropriate financial decisions," and "implement systems to increase productivity in reaching *break even* financial performance." (*Id.* at p. 4, italics added.) The jury also reported: "Almost every person interviewed indicated the need for improvement in efficiency and effectiveness and a continued emphasis on these initiatives. The Grand Jury was told however, that buy-in from the rank and file *remains inconsistent throughout the organization*." (*Id.* at p. 6, italics added.)

Dr. Carl Kirsch is the chairperson of VPG. Following the first MOU, VPG representatives participated in a joint labor management committee focusing on implementation of the terms of the agreement. From November 2011 to April 2012, Reese was a member of this "implementation committee" focused on the details of installing the negotiated terms. Reese joined VPG's bargaining team for the second MOU negotiations, as the only prior member of the implementation committee. He raised issues from the implementation committee experience in the bargaining sessions, including a dispute over compensation for pager calls. The second bargaining team also included Kirsch, chief of pulmonary medicine, Dr. Byrne, chair of obstetrics, and Dr. Kafi, chief of dermatology. The negotiations became more tense around issues of workload and compensation.

Kirsch testified without contradiction that during the three years over which the parties negotiated the second MOU employee morale was poor. This followed the Legislature's adoption of the Public Employees' Pension Reform Act, which compelled increased employee contributions to the plans. The SCVHHS experienced high turnover in the bargaining unit. Physicians, who are attracted to the County because of their passion for the "mission" which they construe as quality care, complained of excessive workload that jeopardized patient safety.

In VPG's view, workload had risen to an unsustainable level. During the second round of bargaining, the County rejected a salary grid system, though it did agree to across-the-board increases. Arnold participated as a member of the County's bargaining team in these negotiations from late 2013 through late 2014. Kirsch described him as being "passive" and sometimes distracted by his cellphone during the sessions.

According to the unrebutted testimony of Kirsch, Arnold insisted that workload needed to increase by degrees. In defense of the increased workload and physician turnover, Arnold employed certain analogies. He described a transition to a "Costco"-level, medical care where volume is valued over optimal quality. He described the physician staff as a bus, where physicians get on and off at stops along the route.

Urology Staffing and Succession Issues

With five physicians, urology is a medium-sized division within the surgery department. The subspecialties in surgery are required to schedule time in the operating room (OR). All specialists spend their time performing their operations, seeing patients in "clinics" (appointment times), supervising residents (teaching activities), and engaging in care coordination activities. With care coordination occurring during "administrative time" (e.g., consulting with other physicians, returning telephone calls, answering patient questions, and charting), a urologist's time is divided between OR time, clinic time, and administrative time.

Reese was appointed division chief in 1996. He arrived six years earlier with the objective of establishing a practice in urologic oncology. Reese graduated from Johns Hopkins University School of Medicine and completed his residency training at Stanford. His resume indicates he has been a chief resident, clinical associate professor, co-program director, laparoscopic/robotic training program director, and deputy chief for Stanford's urology department. He has received funding for clinical studies and is published on numerous occasions over a twenty-year period. Reese described the urologic rotation for Stanford University residents as one of the best at SCVMC. The 2012 U.S. News and World Report ratings of hospitals ranked SCVMC second behind Stanford in Santa Clara County, citing urology as one of four high-performing subspecialties.

In October 2013, Reese sent Arnold an email in which he directly raised issues of staffing and his idea for transitioning out of his chief position. As indicated in the email and testified to by Reese, Arnold ignored his attempts to meet for a number of months. Reese explained in the email that he had suffered back spasms as a result of his complex and lengthy oncologic surgeries. This prompted him to consider the need to scale back his workload over the "next few years" while remaining division chief over that period of time. Reese expressed the value of hiring someone with oncologic experience. He opined that his current staff were either uninterested or inappropriate to serve as his successor. Reese suggested that robotic surgery was increasingly becoming standard for certain procedures and proposed gaining access and training to such an instrument by rental, as had been done for ultrasonic kidney stone procedures. Reese concluded by describing his division as "maxed out" due to the increasing workload, despite adoption of a scheduling change. Accordingly, he requested consideration of additional hires. Reese noted that the urology department at Kaiser in Santa Clara had twice the staffing as SCVMC. The nearing graduation of two clinical fellows provided an opportunity to address his concerns. Reese cited the national trend toward shortages in future urologists as a reason to be proactive.[9] Lastly, Reese alerted Arnold to the need to renew the contract of Dr. Rajesh Shinghal, a non-permanent physician with a skill in stone removal, whose contract was expiring in January 2014. Shinghal had competing obligations at another facility.

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[9] Reporting prepared for the Association of American Medical Colleges estimated a shortfall of 46,100 to 90,400 physicians for 2015. The shortfall is estimated to increase to between 61,700 and 94,700 by 2025. The supply of surgical specialists is expected to decline by 2025, with retirements projected to have the greatest impact. The supply of ophthalmology and urology specialists in particular is expected to remain flat despite increased demand. (IHS Inc. "The Complexities of Physician Supply and Demand: Projections From 2014 to 2025, 2016 Update, Final Report," Apr. 5, 2016, pp. v, 8.)

In the fall of 2014, one of the urologists, Dr. R.,[10] a specialist in reconstructive surgery, abruptly gave one month's notice of his resignation in November 2014. Reese analyzed the volume of referrals to urology, triaged them to cull out the urgent ones, and requested additional work-ups by the referring physicians. He coordinated with a primary care physician leading a project on efficiencies. Reese concluded that there was a capacity issue. He requested from Arnold an immediate replacement of Dr. R. and an additional clinician based on the volume of referrals. Arnold referred him to the finance department, claiming it was necessary because of a protocol that had developed to handle competing requests. Arnold ultimately agreed to hire two new members in the division, which amounted to an increase of one from the time when Dr. R. was employed. Shinghal was not renewed until March, and the division had been forced to cancel surgeries as a result.

<u>Assembly of Management Review Team and Interactions With Urology</u>

SCVMC hired Dr. Paul Russell in October 2013 to be the medical director for ambulatory and community health services, reporting to Arnold. He was responsible for specialty care until that responsibility transferred to Dr. Ghosh in early 2015. During his interview, Russell was told by Arnold that SCVMC was a "provider-centric" system that needed to be transformed to a "patient-centric" system. Russell testified that one of the principal issues he identified was one related to clinic staffing. This was a matter he believed was left to the discretion of providers, leading to inefficiencies. For example, staffing was an issue in oncology where support staff had difficulty scheduling patients because multiple physicians had scheduled their administrative time during the same clinic, resulting in lack of

[10] The full name is redacted due to privacy concerns related to allegations of inappropriate conduct described hereinafter.

appointment times. In regard to surgery, Russell believed the physician schedules were not sufficiently "robust" and "transparent" so as to account for the location of physicians during administrative time.[11] In ophthalmology, some providers were not attending to their administrative time in the office, which led to lack of coverage if the regularly scheduled physician was absent due to illness, etc. Russell met with the providers, including the chief of ophthalmology who had this practice, and directed that the practice cease. Russell identified a similar practice in the primary care clinics. Russell addressed problems with the clinics failing to schedule physicians for enough clinics. The chief of primary care was relieved of oversight over the operational matters and medical director positions were created and ordered to report directly to Russell. In specialty care areas, Russell focused on "significant" problems including backlogs in ophthalmology, gastroenterology, hematology, oncology, and neurology. Referral issues were a major concern in gastroenterology and ophthalmology. Some concerns about access were identified for urology, though the problem was a "broad" one. After Russell was relieved of specialty care oversight, medical directors were appointed to manage operational issues in oncology, ophthalmology, and urology.

Russell had three interactions with Reese. Reese requested Russell's approval for contracting with another facility for use of their Da Vinci surgical robot. After reading two articles that were not supportive of the device, Russell asked Reese to provide better clinical data in support of his request. Nothing further came of the matter. The second occasion

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[11] The first MOU included language that required an "ongoing process" by which the divisions and departments would establish work schedule templates that would be approved by management. This language permitted management to change physician schedules to address the needs of management consistent with certain factors. Reese testified that following the first MOU, Arnold's predecessor, who was a member of the implementation committee, had approved urology's schedules "to the minute."

pertained to Dr. R.'s request to use Reese's vacant OR time but only on condition that he reschedule his clinic appointments. Dr. R. was very upset. Reese sided with Dr. R.'s preference not to change his administrative time. Russell conceded the challenge of rescheduling patients existed across all specialties. On the third occasion, Reese had allowed more than 50 percent of his staff to schedule time off during the 2013 Christmas period, which was out of compliance with the expectation of maintaining 50 percent staffing during holiday periods. Although he discovered the issue after the fact, Russell recalled no resistance from Reese regarding his counseling on the matter.

Dr. John Siegel was hired at the SCVMC in September 2013. Siegel was aware of no issues in the urology department when he started. In 2014 he became the director of perioperative services, a position on the executive management team with oversight over the departments of surgery, anesthesia and orthopedics. He was to be an intermediate manager between Arnold and Adams. Siegel had prior experience as a hospitalist, including in private practice. In 2014 he became aware of the issue of long waiting lists in a couple of the surgery divisions, notably, urology and ear, nose and throat. Siegel provided no testimony about how he attempted to address the situation. He had no issues with Reese's productivity and admitted that beginning in late 2014, when caseloads were increasing throughout surgery, Reese requested additional blocks of time in the OR.[12]

Siegel next identified the lack of transparency in the work schedules for the surgery department, citing the potential for abuse related to administrative time. He acknowledged that administrative time is the "glue" that holds the practice together. He cited three anecdotal

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[12] Siegel believed that urology was down to one urologist around the time Reese pressed for the renewal of Shinghal's contract. Though Reese did not confirm that to be the case, this demonstrates Siegel's impression of urology as having a serious staffing issue.

instances of misuse of administrative time, including the case of Dr. R.'s taking guitar lessons.[13] Dr. R. gave notice of his resignation sometime after he was counseled by Reese regarding this issue. Siegel never spoke to Reese about Dr. R.'s alleged misuse of time. Siegel was asked if he could cite any more than the three instances. He could not.

After Dr. R. left, Siegel reported to Arnold that Dr. R. had been checking out surgical instruments. Arnold told him that was not allowed. Siegel did not have an opinion on whether it was allowable or not. Siegel also testified that urology was "underperforming" in terms of "RVUs," a metric used to value surgical procedures.[14] Although he believed transparency needed to improve and Reese needed to pay more attention to issues like those with Dr. R., he could not make any judgment about Reese's ability to address these issues on his own. Siegel also testified that at some unspecified time he discussed the leadership change with Adams, though it was Arnold's idea to ask Reese to step down. Siegel acknowledged that while there was some agreement on Adams's part, Adams pushed back, believing it would be disrespectful. Siegel testified that Arnold told him urology was "bleeding capacity" or not "really utilizing capacity" as evidenced by some cancer patients transferring out to get procedures done more quickly. Siegel did not discuss the matter with Reese.

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[13] In the implementation committee meetings, VPG noted that there had been an understanding that administrative time did not have to be performed during business hours, but that practice changed, apparently without negotiations.

[14] Relative value units are used by the Centers for Medicare and Medicaid Services to rank on a common scale the resources required to provide each service. These resources include the physician's work, the expenses of the physician's practice, and the cost of professional liability insurance. (National Health Policy Forum, "The Basics, Relative Value Units (RVUs)," Jan. 12, 2015.) Reese testified that he had some concerns about physicians been evaluated on the basis of RVU production because it was weighted toward procedures with higher reimbursement rates. According to Reese, Kaiser does not rely on the RVU metric to evaluate physicians.

Arnold identified two leadership challenges he addressed. The first dealt with the wait times between the emergency room and hospital admission that significantly exceeded state averages. A medical director was brought in to assist the chief of hospitalist medicine because of the "huge" nature of the system. In the fall of 2014, Stanford's ophthalmology department requested a change in the chief because residents reported issues regarding patient access, lack of supervision, unaccounted for time, and patient complaints. Arnold did not explain the nature of the operational issues there, although Dr. Ghosh identified them. Arnold explained that because he is "pretty far up the mountain," complaints from chairs and physician executives or data revealing longstanding problems have prompted him to initiate leadership changes. The Stanford chief recommended a candidate for chief of ophthalmology but the candidate was not board-certified and that proposal "stalled out" in 2015. Eventually a medical director was appointed for ophthalmology.

Arnold learned of the wait times for urologic surgery and also received a request to move post-operative urologic oncology patients from the oncology unit to urology because of insufficient demand. He heard that Dr. R. "might" have been operating at Stanford on County time and misusing administrative time, which was not actually needed "because there was other time on top of that that was also sort of falling into the white space of unidentified time."

Adams knew that urology was a topic of discussion amongst Arnold, Siegel, and Russell in terms of the long wait-times for patient referrals. He did not understand why urology was singled out because the issue was systemic. He was aware of the lag time in hiring the replacement for Dr. R. and the additional position approved by Arnold. He noted the lack of accountability issue as to Dr. R., but it was one that existed throughout his department and was addressed. Adams was aware that Reese counseled Dr. R., which led to Dr. R.'s

departure from SVCMC in the fall of 2014. No one raised the issue with him of Dr. R. "refusing to have clinics on this administrative time." Adams denied having any discussion with Arnold about a conflict between a physician's personal interest and his work responsibilities.

Recruitment of Dr. Ngo

In some fashion other than through Reese, a urologist named Dr. Tin Ngo came to Arnold's attention in late 2014. Ngo had been a SCVMC-Stanford resident. He was two years removed from his residency. He grew up in the area, but was working in Fairfield. Ngo had started but withdrawn from a fellowship in oncologic urology. He was not yet board certified. Arnold did not coordinate with Reese on the recruitment of Ngo. After an informal interview with Ngo in December 2014, Arnold felt he found a "great candidate" who was a "servant leader" focused on patient satisfaction. Ngo discussed matters that were "opaque" in Arnold's discussions with Adams.

In January 2015, Arnold coordinated with Reese to explore potential candidates from the University of California, San Francisco. Reese identified Dr. Catherine Harris, who had completed the same reconstructive surgery fellowship as had Dr. R.

In approximately February 2015, Arnold told Adams that Reese was not the "correct person" to be leading the division. After some waiting, Ngo contacted Reese to ask for an explanation of the status of his application. Arnold offered Ngo a position in March 2015. Ngo commenced employment in June.

Arnold informed Adams of Ngo's hire, but not Reese. Adams told Reese not to contact Arnold at this point because he was "getting under [Arnold's] skin." Reese planned on working with Ngo to allow him to complete his oncology fellowship. After Ngo accepted the

position offered, Reed called Arnold's office to request a copy of his employment contract. Contrary to past practice, he was not provided one. Harris was hired as to an 0.8 full-time position and commenced work on August 3.

Arnold testified that after bringing clinic schedule, OR use, and RVU data to Adams, his management team hoped Adams would start to address the issues. In describing his interactions with Reese, Arnold did not mention any of these issues. He described a discussion about the Da Vinci robot and Reese's request to fill staffing vacancies. He had only a vague recollection of the issue with Dr. Shinghal's retention, claiming he agreed with the need to retain him.

Arnold testified that Adams agreed with the need to replace Reese after he was shown the RVU data, and "all the access problems." Arnold asserted that process improvement could not occur until there was a leader willing to get a team together to make it happen. Arnold testified he was trying to get Adams to "engage in it and to really get into the weeds in his divisions," until he reached the point that he felt a change had to be made. Sometime after Ngo was identified as a potential new hire, Arnold proposed to Adams the idea of having Ngo replace Reese. After discussing the idea with Adams, Arnold believed that Adams agreed with Ngo taking over the chief role. He thought Adams would work out something "humane" for Reese.

Ngo testified that Arnold hired him to "fix access problems" in urology, despite only being offered a regular position at the time of his hire. Ngo had succeeded in reducing wait times at his former position at his previous employment at the North Bay Health Center. According to an email he wrote, Ngo discussed reducing the considerable backlog and improving access in his interview with Arnold.

In March, Adams "stunned" Reese by informing him that Ngo would be replacing him as chief of the division. When asked for an explanation, Adams told Reese that Arnold's decision was not based on logic but his personal view of Reese. While Adams agreed with Arnold that Reese's strengths were not on the "operational" side, Adams objected to Arnold's request that Ngo replace Reese as division chief for two reasons. First, it would violate his department's rules which require a division chief to be board certified, and Ngo had not been certified. Second, it was premature. Adams understood Reese's intention to identify and groom a successor, but saw that as coming a couple of years ahead, after his successor - if it was Ngo - had established himself and been vetted by the division itself as their leader. Adams summed his opinion up by stating that Ngo lacked "gravitas." After Reese conveyed to Adams that he suspected retaliation for his activities on behalf of VPG, Adams relayed Reese's suspicions to Arnold. Adams believed Arnold's plan could indeed be viewed as such. He testified that he believed that fear of "retaliation" and "discrimination" is a "common theme" in the County. In response, Arnold wrote in an email to Adams that he saw no connection between his proposal and Reese's VPG activity, adding he could promise there was none. Arnold confirms that his plan was for Ngo to assume leadership on "day one," though Ngo was willing to defer until August 1.

Arnold stated that leadership change was needed in a "health system that needs to rapidly change to survive." Arnold testified that his decision was informed by complaints from physicians and access information shared by Russell and Siegel. A physician in radiation oncology wanted post-operative patients transferred out of the cancer center to urology because patients were complaining and she felt it was a misuse of her time to see them. Arnold raised these issues with Adams, but not Reese, because the chair "owned and operated" the divisions

within surgery, and he expected Adams to address it. When asked about his meetings with Reese, Arnold did not mention any of the capacity issues being raised, only Reese's request for staffing and the Da Vinci robot.

In May, Reese discovered that Harris's starting salary was lower than Ngo's by one dollar per hour, which he presumed to be a mere clerical error. He asked Adams to raise the issue with Arnold. He heard nothing from Adams for about one month. Eventually, Adams reported that Arnold believed the difference was justified because Harris had not completed her fellowship. Reese felt the rationale was absurd because Harris had completed her fellowship and, even if that were true, it would not justify a one-dollar-per hour difference. Ultimately, Reese asked Adams to convey Reese's offer to make up the difference himself. The offer was not accepted.

<u>Dr. Arnold's Proposal To Name Dr. Ngo as Interim Chief or Medical Director</u>

Once Ngo arrived, he worked extraordinarily hard to process cases. Ngo was disturbed by the long wait times for urology referrals. He allowed the front desk to schedule additional cases for him. He took extra shifts and forwent administrative time. According to Reese, Ngo focused entirely on "cranking out" the cases when he arrived. Ngo described himself as using "brute force" to work down the referral lists. Reese noted that Ngo had neither prior teaching experience nor any interest in that or research. Nevertheless, Reese believed Ngo had very good intentions when he began and saw an opportunity to groom him for leadership.

Reese gave Ngo the opportunity to take on operational issues. He tasked Ngo with examining the referral lists. These included repeats of previously referred, but not yet seen, patients. Ngo obtained access to the referral lists, prioritized high risk and urgent cases, and was responsible in large part for reducing wait times. He had the patients contacted, which

differed from the prior practice.[15] Some of the urology referrals were for the same patient who had not been seen. Once these patients were identified, the absolute number of the backlog was reduced. Within a month of starting, Ngo had several discussions with Arnold about making changes, but told him he needed authority. Reese also tasked Ngo with setting up the clinic for the patients previously seen in radiation oncology.

In June, a charge nurse in urology, Natalie Waite, sent an email complaint to Adams, complaining about Reese's leadership. She claimed he was falling asleep during clinic time, cancelling clinics with extremely short notice, being slow to respond to emails, etc. Despite his great skill as a physician, Waite complained that Reese's behavior was causing morale problems. Reese admitted he had dozed off at times during work, but it was due to the extremely heavy caseload and lacking two physicians for six months. His slowness in responding to emails was attributable to the burdens of the new EMR system. Reese contended that not all nurses were in agreement with Waite's opinion. He discussed the matter with Waite. Adams shared the complaint with Reese, who in turn shared it with Ngo. Ngo told Adams he thought he could assist with the issues, but needed some "authority to make changes."

MEC President Dr. Phuong Nguyen testified that Arnold approached her in June 2015 to ask her if she interpreted the bylaws as preventing him from appointing a medical director for urology. Arnold told her that his interest in creating such a position was to provide "additional support" to improve access. He did not describe the proposal as relieving the division chief of his duties and transferring them to the new position. Nguyen testified that

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[15] Arnold testified this kind of passive-aggressive practice of responding in terms of the urgency of the patient's demand was one to which he objected in his prior emergency department experience.

both the MEC and VPG are entitled to present an objection to such an appointment and that it was "good practice" for "everybody [to be] on the same page" if the matter involved the medical staff. Nguyen did not bring this matter to the attention of VPG. Arnold explained to Nguyen that the issue of additional administrative support had been discussed with Adams as to divisions within the department generally. He did not report that Adams had any dispute or difference of opinion regarding the creation of a medical director position within urology. Nguyen told Arnold that she did not believe the bylaws prohibited the creation of a medical director position for urology.

By early July, Reese gave a favorable report to Adams, explaining that Ngo was "taking ownership" within urology and working actively with the support staff on referrals. At the same time, Ngo reported his successes to Arnold. Arnold testified he had no idea who gave him the Waite complaint, but it was sent to him somehow.

The report on Ngo confirmed Arnold's view that it was time to have Ngo replace Reese. On July 22, Arnold informed Adams in an email that he was proposing to have Ngo named "interim chief" as of August 3. But, this, too, failed to satisfy Adams. Arnold explained to Adams that the title would achieve "alignment" between the departmental goal of the permanent chief being board certified, Ngo's goal of completing the board certification process, and the "organizational interest in getting the right people into leadership positions as soon as possible." Arnold described swift action as necessary to achieve the Triple Aim within an "increasingly competitive and disciplined external environment," specifically improving access. Arnold concluded with a suggestion of working with Nguyen to "reconcile" the department's rules with the medical staff bylaws (i.e., change the department rules to conform to the MEC bylaws. He added:

> We have been having a lot of conversation over the past two years about where the boundaries lie between the Medical Staff, employment status, professional business interests (e.g., VPG CEPA, Stanford), and academic interests (e.g., Stanford), so this represents a good time to engage and update. I think we all agree that the Medical Staff's interests are in preserving and improving the quality of medical care that we deliver to patients, so department policies that focus on clinical quality would be very welcome re both [t]he Joint Commission/CMS[[16]] and the Triple Aim.

Arnold described the boundaries issue akin to a "church" (medical staff) and "state" (administration) issue. Adams denied they had ever discussed the "boundaries" issue.

Adams told Arnold that Ngo could not be named interim chief because he was not board certified as required by the surgery department rules. Adams testified that in the meantime, Ngo told him the he had the authority from Arnold to make changes in urology, none of which had been communicated to Adams by Arnold. Adams relayed the message to Reese, informing Reese that he would have to step down as of that date. Adams agreed that leadership change was needed, but disagreed fundamentally with the timing, adding that it was disrespectful to Reese. Adams's demeanor on the witness stand reflected great umbrage at Arnold's attempted installment of Ngo.

On August 19, Ngo reported to Siegel that Reese had "basically ordered [him] to go home" and not to perform two "overnight" surgeries, so Reese could perform them the following day due to a last-minute cancellation of a "big" case on Reese's schedule the next day. Ngo stated: "I don't know if this fits into your criteria of inappropriate cancellations of

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[16] The Joint Commission/CMS presumably refers to the national hospital accrediting organization processes involving the Centers for Medicare and Medicaid Services and the Joint Commission for the Accreditation of Healthcare Organizations. In order to be eligible for federal reimbursement, hospitals must be working toward improving quality of care and patient safety.

add ons but without any real authority there wasn't much I could do about it." Siegel passed on the email to Arnold, stating, "this is the latest in what appears to be standard practice among many surgeons across all divisions. . . . There's no reason for the delay noted in the chart because there wasn't a reason, they just don't feel like operating in the evening." After citing another routine case that was bumped and dismissing literature pointing to risk of complications because it only applies to complex cases, Siegel added, "[A]lso postponing cases until the next day assumes that there'll be an OR available first thing the next day, which is almost never the case. . . . " Siegel concludes, "with attitudes like this, it's no wonder the surgeons can't generate wRVU!" Siegel admitted he did not know if Reese had open OR time the following day to perform the surgeries. Siegel testified this was an example of cost inefficiency because the patients were discharged a day later than was necessary.

One week after Reese communicated his offer to address Harris's hourly rate issue, Adams informed Reese that he would have to step down from his position as division chief. Sometime in August, Arnold increased Ngo's pay equal to Reese's without informing Reese of the circumstances. On August 27, Reese asked Ngo about it, seeking to know the context. Ngo asked Siegel for advice. Siegel told him to respond honestly and as he saw fit. Ngo responded to Reese that he did not question it and assumed it was for a job well done. At the hearing, Ngo testified that Arnold increased his salary in advance of his being appointed medical director because of the challenge in appointing Ngo as the new chief.

On August 31, Arnold issued an announcement that Ngo had been appointed medical director of urology effective September 1. Ngo had informed the staff shortly before this date. Reese left for a vacation believing he might return to find himself terminated. After Arnold's announcement, Ngo informed the staff that Reese would remain division chief, but without

responsibility for operational matters. Reese's pay remained the same, though he estimated his leadership duties were reduced to 10 percent.

Siegel testified that Arnold's idea of creating medical director positions was to advance the "business aspect" of the practice. When Arnold began there were "executive leadership positions," titled medical director, for various programs like behavioral health, information technology, perioperative services, and patient safety. On the clinical side, there were two medical directors for trauma and genetics, for reasons not explained. Beginning in early 2014, Russell off-loaded operational responsibilities from the chief of primary care to a medical director at each of the seven primary care clinics (rather than the previous one), all reporting to him. On the acute care side, medical director positions were established for hospitalist medicine to manage in-patient flow across the entire system.[17] As to specialty care, Arnold made proposals for medical directors for ophthalmology and urology. The chair of radiation oncology was made medical director for hematology oncology to manage operational matters because the chief of that division was a Stanford faculty member. VPG bargaining team members, Drs. Kirsch, Byrne, and Kafi retained their chief or chair positions throughout this period.

Phuong testified that "in the old days, [chairs and chiefs] were chosen because we were the most respected person in the department or division who people trust, and not necessarily looking for an operational mind type of people [sic]." Adams testified that the removal of chief duties from Reese violated the medical staff rules. He believed that Ngo's installation

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[17] The medical staff bylaws identify one "medical director" position, appointed by the chief medical officer and whose function is described as an "administrative liaison among hospital administration, the Governing Body outside agencies and the Medical Staff."

interfered with the authority vested in the division chief position as set forth in the MEC bylaws:

> I think that Dr. Ngo came with a very specific set of guidelines that he was to follow and he made those very clear to Dr. Reese and me. He made it clear that he was working under the color of authority of the CMO, that there were changes that needed to be made.

At a regular meeting of the chairs on September 8, Arnold presented a Powerpoint presentation that outlined the responsibilities of medical directors, which included management of providers (staffing, assignments, scheduling, time-reporting, recruiting, non-medical-staff evaluation), and system management (performance, access, patient experience, productivity, resource utilization, and care coordination).

In a September 16, 2015 exchange of emails between Adams and Arnold, in which Adams responded to the presentation, Adams reported that Ngo's installation had taken the urology staff by surprise with a feeling that Ngo was a "tool" of Arnold, resulting in animosity from the staff toward Ngo. Adams reported that Ngo informed him that he was emphasizing RVUs, which apparently originated with Arnold. Adams recommended that Arnold make a wider announcement to the surgery department that this metric was being elevated.[18] While expressing interest in helping Ngo succeed, Adams was "surprised how protected [Ngo] felt in his new position." Adams expressed concern about Ngo's potential for failure, citing these and other factors, including his aborted oncology fellowship. He questioned Ngo's ability to succeed as a "change manager." Adams noted:

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[18] Reese suspected that Ngo was steering cases with high RVU value to himself. Under Reese's leadership case assignments were handled collaboratively amongst the staff. At the hearing, Ngo called Reese's claim "intellectually corrupt."

> I also spoke more generally about change management and the need for leading rather than pushing, and the value of communication and collaboration . . . . [A]ll he has now is the aura of the authority of Medical Administration, and a somewhat smug sense of predestination I do not see this as a good long term solution for a successful change manager.

In October 2015, Reese reported to Arnold, Ghosh, and Siegel about the progress that had been made in reducing the backlog following the arrival of Ngo and Harris. He requested that in order for the progress in access to be maintained that Harris's time be increased from her 0.8 starting assignment to a full 1.0 position, and that Shinghal be retained. Ngo felt compelled to correct the record with Ghosh and Arnold because Reese was unfairly "leveraging" his own contributions. He disputed that Reese had tasked him with reducing the backlog, stating that he had discussed that goal with Arnold before he started. Ngo also wanted Ghosh to know that Reese had warned Ngo that if there was too much production it would raise the expectations of management. Reese did not dispute that he made this statement, though he believed Ngo's initial pace of working seven days per week and taking no vacation during his first year was unsustainable. In terms of leadership grooming, Reese also was suggesting to Ngo that comparing his production to that of others was not a good strategy for improving the productivity of the staff.

In 2016, Ngo established a goal for RVU that would exceed prior levels. In May, Ngo reported to the staff that first quarter per capita RVU had increased over 2015 levels. The following day, Reese addressed the entire staff in an email cautioning that RVU performance was not referenced in the MOU. He questioned whether goals set by management were sustainable given the team's teaching responsibility. Ngo responded that the staff needed

> to be realistic and accept the fact that this is the new world order and this is how things are everywhere. It's the result of healthcare reform, consolidation, etc., etc. . . . . I've always felt

> that working with the administration rather than fighting with them gets us further in the long run. . . . Now that the MOU has been voted on and likely to pass, we need to drop the confrontational stance and try to be more collaborative.

After the unfair practice charge was filed, Ngo asked Reese if he would withdraw the charge. He added that if Reese did not, Arnold "would come after him with everything he had."

ISSUES

(1) Should the charge and complaint be dismissed and deferred to arbitration?

(2) Did the County discriminate or retaliate against Reese because of his protected activities?

CONCLUSIONS OF LAW

The complaint alleges that the County discriminated against Dr. Reese by "removing" his duties as chief of the urology division. Although Reese retains his formal title and salary, Reese contends that reassignment of the bulk of his administrative duties caused him to suffer an adverse action. Reese claims that Dr. Arnold's decision to install Dr. Ngo was motivated by Reese's activities on behalf of VPG.

The County contends that Arnold's decision was based on his assessment of inadequate leadership on Reese's part with regard to operational matters in urology and his preference for Ngo because of Ngo's commitment to addressing issues of concern to management. The County further contends that the issue of discrimination need not be reached because the complaint should be dismissed and deferred to arbitration.

Deferral to Arbitration

In *State of California (Department of Youth Authority)* (1992) PERB Decision No. 962-S, PERB held that deferral to grievance arbitration under an expired collective agreement is appropriate if the parties' dispute: (1) involves facts and occurrences that arose before expiration of agreement; (2) involves post-expiration conduct infringing on rights accrued or vested under the expired agreement; or (3) involves a contractual right that, under normal principles of contract interpretation, survives expiration of the agreement. (*Id.* at p. 10, citing *Litton Financial Printing Div. v. NLRB* (1991) 501 U.S. 190 [*Litton*].) Applying *Litton*, PERB found that a contractual provision prohibiting retaliation against employees because of protected activity neither created a vested right nor a right surviving expiration under principles of contract interpretation.

Here, the alleged adverse action occurred in the summer of 2015 in the period after the agreed upon extension of the first MOU but before commencement of the successor MOU. The County relies on the language of the expired MOU prohibiting discrimination and retaliation for protected activities. While acknowledging that PERB refused to dismiss the case at the investigatory stage because of the expiration of the prior MOU, the County contends that expiration "did not in any way change the terms of the agreement" and the County continued to honor the terms and conditions of the expired agreement. The County presents no argument or analysis explaining why the no-discrimination provision constitutes a right vesting during the expired MOU or one surviving expiration by virtue of contract principles. The County adherence to the employment practices established by the prior MOU merely avoided being charged with a unilateral change violation. (*Litton*, *supra*, 501 U.S. at pp. 198-200, 206-207.) The County has failed to cite grounds qualifying as one of the *Litton* exceptions. The County's

duty to arbitrate this matter failed to survive expiration of the prior MOU, and PERB is precluded from dismissing and deferring this charge and complaint to arbitration. (*State of California (Department of Youth Authority)*, *supra*, PERB Decision No. 962-S, p. 11.)

Discrimination

To demonstrate that the County discriminated against him in violation of MMBA sections 3506 and 3506.5 and PERB Regulation 32603(a), Reese must show that (1) he exercised rights under MMBA, (2) the County had knowledge of his exercise of those rights, (3) it took adverse action against him, and (4) the action was taken because of his exercise of those rights. (*Novato Unified School District* (1982) PERB Decision No. 210; *County of Yolo* (2009) PERB Decision No. 2020-M.)

The charging party has the initial burden of demonstrating the "because of" element, that is, a connection or "nexus" between the adverse action and the protected conduct. (Sec. 3506.5; PERB Regulation 32603(a); *Novato*, *supra*, PERB Decision No. 210, pp. 5-6.) "Unlawful motive is 'the specific nexus required in the establishment of a prima facie case' of retaliation." (*Cabrillo College Community College District*, *supra*, PERB Decision No. 2453-E, p. 10, quoting *Novato*; *County of Yolo*, *supra*, PERB Decision No. 2020-M.) "[D]irect proof of motivation is rarely possible, since motivation is a state of mind which may be known only to the actor. Thus . . . unlawful motive can be established by circumstantial evidence and inferred from the record as a whole." (*Ibid.*) Facts establishing that the adverse action was taken "because of" the exercise of protected activities may be shown by the following factors: (1) timing of the employer's adverse action in close temporal proximity to the employee's protected conduct is an important factor, (2) the employer's disparate treatment of the employee, (3) the employer's departure from established procedures and standards when dealing with the employee, (4) the

employer's inconsistent or contradictory justifications for its actions, (5) the employer's cursory investigation of the employee's misconduct, (6) the employer's failure to offer the employee justification at the time it took action or the offering of exaggerated, vague, or ambiguous reasons, (7) employer animosity towards union activists, and (8) any other facts that might demonstrate the employer's unlawful motive. (*County of Yolo*, *supra*, PERB Decision No. 2020-M; *Novato Unified School District*, *supra*, PERB Decision No. 210.)

Once a prima facie case that protected activity was a motivating factor for the adverse action is established, the burden shifts to the employer to demonstrate that it would have taken the same action even in the absence of the protected conduct. (*Novato, supra*, PERB Decision No. 210; *McPherson v. Public Employment Relations Bd.* (1987) 189 Cal.App.3d 293, 304.)

There is no dispute in this case that Reese engaged in protected activity by serving as a bargaining team member and implementation committee member, and that Arnold knew of those activities. The County only disputes the adverse action and nexus elements.

The adverse action element is satisfied. Despite his pay not being reduced and his title remaining unchanged, Reese reasonably perceived the removal of an estimated 90 percent of his independent judgment functions as a division leader to be an adverse action. (*Trustees of the University of California* (2009) PERB Decision No. 2038-H, pp. 11-13.) The transfer of those duties led to changes in the way he and his colleagues performed their work due to the changes Ngo was expected to implement, including but not limited to, per capita RVU goals. Moreover, because of Reese's prominent role in the establishment of VPG's new found authority with respect to negotiable subjects, the stripping of his lead duties can be construed as having a chilling effect on other potential activists in VPG. (See *County of San Joaquin*

(Health Care Services) (2001) PERB Decision No. IR-55, p. 13.) It is the nexus element that requires the close analysis.

The case for proof of unlawful motive generally proceeds from circumstantial evidence. Context is always relevant in determining motive. This is particularly true when the decisionmaker's personal and professional interests stand in direct opposition to protected organizational interests sought to be advanced by the charging party. In such instances, scrutiny of the justification for the adverse action must be heightened because the evidence of nexus is more direct.[19] (See *County of Yolo*, *supra*, PERB Decision No. 2020-M, p. 13 ["any other" facts supporting unlawful motive aside from traditional factors]; *Rainbow Municipal Water District* (2004) PERB Decision No. 1676-M, adopting adm. law judge's proposed decision at p. 10 [acts done in furtherance of union interests are protected].) An adverse action that substantially advances the prerogatives of management while threatening the interests of the union is evidence of unlawful animus.

Arnold claimed that his need to evaluate division leadership across the board stemmed from the external environment; specifically, the effects of the PPACA goal of expanding insurance coverage that led to 50,000 new patients coming into the system. The record offers no evidence that the County intended to ameliorate this influx with an expanded physician staff. Arnold was reluctant to commit to Reese's requests for replacements at a time when

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[19] The opportunity to advance interests of the employer that are opposed by the exclusive representative in a discrimination case has greater tendency to prove unlawful intent, unlike a case where a low-level manager imposes discipline for misconduct having no direct relationship to protected activity. In circumstantial cases of various kinds motive typically aligns with opportunity.

urology was seriously understaffed.[20] And he was openly committed to ratcheting up the intensity of work over time.

Resistance to expanding staffing up to meet increased need was not entirely unreasonable during this period given inability to predict the political and/or legal sustainability of the PPACA. But requiring the existing staff to bear the burden of the increased patient load was a fundamental point of contention with VPG. The County, as a safety net provider, also stood to benefit financially from the extended coverage, because patients who had been uninsured would now have their otherwise uncompensated care reimbursed by through Medi-Cal or Covered California insurance plans.

Simultaneously, County physicians, drawn to the County's public mission over other terms and conditions of employment found elsewhere, were finding employment with the County less tolerable as the workload rose. Arnold did not take issue with this contention of VPG. Added to that challenge, the PPACA included provisions for improved patient outcomes for purposes of cost containment (through EMR, increased care coordination activities, emphasis on primary care, etc.), but did nothing to address the immediate scarcity of physicians in relation to new patient demand.[21]

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[20] Indeed, the County asserts in its post-hearing brief that the only thing Reese did to address the challenges in his division was to ask for more staff.

[21] An essay discussing the PPACA's impact on the physician supply acknowledges initiatives supported by the legislation, including team-based redesign of care delivery, EMR, and coordinated care, but questions the ability of these measures --- intended in theory to off-load work from physicians to other care team members --- to succeed in addressing the shortage. (C. Montgomery, "The Physician Shortage and the Future of the Affordable Care Act: The Coverage Without Care Conundrum," Stanford Journal of Public Health, Oct. 20, 2013.)

Arnold explained his goals through his interpretation of how the Triple Aim translated to the SCVMC. The first two goals had direct impacts on the way in which physicians approach their work. The first was moving away from "individual autonomous doctors" in favor of "team leaders." Though Arnold did not admit to it, this goal was heavily imbued with managerial prerogatives. Arnold's vision apparently did not countenance the current system, whereby Reese worked in a collegial manner as a team leader, meeting with his staff to discuss and distribute the cases. In addition, breaking down physician autonomy is consistent with the ongoing conflicts between non-medical staff management and hospital medical staff governance, where management is compelled to seek greater discipline of the workforce with the goal of improving financial outcomes, including focusing on procedures with better reimbursement.[22] The chief medical officer, reporting to a non-physician management executive team that generally includes a chief financial officer, has evolved to be management's point person for addressing the continuing challenge of increased medical costs and corresponding rise in insurance premiums. In this case, as revealed in his July 22, 2015 email, Arnold's conflict with Adams was an example of his attempt to expand the scope of his authority in the face of the "boundaries" imposed by the competing interests of the medical staff, VPG, and other entities.

The second goal of improving value for dollar spent was accompanied by Arnold's demands for increasing physician workload by degrees and measuring progress through quantification metrics. Through Siegel, reliance on RVU performance became the principal

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[22] See Sandeep Jauhar, "Shouldn't Doctors Control Hospital Care?" New York Times, Oct. 10. 2017 (reporting on the recent conflict between a rural California hospital district governing board and its medical executive staff and arguing that financial pressures have led to the erosion of physicians' autonomy, which arose on the basis of leveraging a "cultural perception of high-minded knowledge").

metric applied to physician performance. Arnold did not dispute that he was seeking a Costco-type delivery system. The analogy reflects the philosophy of commodifying medical care, which is similarly at odds with the traditional autonomy of physicians as highly trained and highly compensated professionals. That vision also implicates negotiable subjects like workload, quantity of administrative time, and related matters.

The third goal of improving patient satisfaction depends on the eye of the beholder. Some patients are more satisfied with quality outcomes free of complications, which aligns with the MEC and VPG's interest in protecting their licenses. Others are more satisfied with shorter wait-times, which aligns with the County's interest in more reimbursed procedures per physician.

The County contends that no inference of unlawful animus can be drawn from the timing of the transition to Ngo because contemporaneously with Reese participating on the VPG bargaining team Arnold, Siegel, and Adams all concluded that Reese should relinquish his position in early 2015. It faults Reese for failing to explain the particular views he asserted at the bargaining table and contends other issues he raised separately (e.g., request for robotic instrument and objection to the salary difference as to Harris coming after Arnold, Siegel, and Adams began discussing leadership change) arose from his position as chief rather than as a bargaining team member. Additionally, the County notes the three other VPG bargaining team members who occupied chair/chief positions but retained their positions. These arguments are not persuasive.

Arnold contended that he was high up in the management structure and relied on his deputies for recommendations. Neither Siegel nor Russell provided persuasive support for Arnold's defense. At the time Arnold identified Ngo as a potential replacement in December 2014, there had been no reported complaints about urology leadership. Arnold concluded at that

time that Ngo was the type of "servant leader" he admired and informed Adams shortly after that Reese was not the "correct person" to lead the division. This occurred immediately after Reese began advocating for replacement of Dr. R. and requesting an additional clinician based on the increased workload. Reese's advocacy for replenished staffing was protected as an extension of his advocacy on behalf of VPG for staffing and as a matter of collective employee concern within weeks prior to Arnold interviewing Ngo. (*City & County of San Francisco* (2011) PERB Decision No. 2207-M.) Reese was participating in bargaining during the time Arnold participated, from late 2013 until late 2014, when Arnold withdrew from participation. The timing factor is established. (*North Sacramento School District* (1982) PERB Decision No. 264, p. 9.)

Russell counseled the ophthalmology division regarding administrative time and lack of clinic coverage. He did not cite urology as having that problem, only primary care clinics, which shortly became the focus of his attention. He cited gastroenterology and ophthalmology as having the prominent backlogs in surgery. He considered the delays in urology to be part of a broader problem. The issue of Dr. R.'s clinic cancellation and the Christmas coverage issue were minor in the context of the issues the hospital was attempting to address. Russell recited no discussion with Adams about Reese's leadership. Dr. Ghosh who was actually responsible for the design changes in the surgery subspecialties was not called by the County.

Siegel had little or no agency in the decision to replace Reese. Siegel testified he was aware of no issues with urology after he started in 2013. He cited the backlog in urology in 2014, the time when Reese reported increasing caseloads to Arnold, but no efforts on his part to address the issue with Reese. He was under the impression that staffing in urology had dropped by 80 percent at some point. Siegel was asked about discussions with Arnold about leadership in

urology, but only discussed asking Reese to step down.[23] Siegel could cite only three anecdotal instances of misuse of administrative time, including Dr. R.'s guitar lessons. Dr. R.'s alleged misuse of administrative time was addressed and he resigned from his position shortly after being counseled by Reese. While the County may have been entitled to prohibit non-work activities during business hours, the physicians had viewed the professional nature of their work to only require completion of their yearly hour quota. Despite the County's emphasis on data collection over the entire system, there were no reports substantiating abuse of administrative time among the County's 800 physicians. (*City of Torrance* (2008) PERB Decision No. 1971-M, pp. 17-18.)

Siegel did discuss the idea of Reese stepping aside with Adams at an unspecified time, but Adams resisted. Adams only agreed that Reese should be replaced after Ngo had been board certified, mentored by Reese, and developed the needed gravitas within the division. Adams became Reese's staunchest supporter once he learned of Arnold's intentions. Despite his stand-offish relationship with Reese, Arnold, in Adams's view, apparently developed a dislike for Reese, resulting in Adams handling all future discussions about leadership change on behalf of Reese beginning in March 2015.

Siegel revealed bias when he was asked to opine on Ngo's August 2015 report about being sent home by Reese instead of being allowed to complete two surgeries that evening. This was long after Arnold had made his decision on urology succession. Ngo appeared to be undermining Reese behind his back and currying favor with management in order to satisfy his repeated suggestions for obtaining greater authority. This is not evidence of team leader skills.

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[23] Siegel could recall no discussions he had with Arnold around leadership in urology the initial time the question was asked.

In his forwarded email to Arnold, Siegel described the incident of a surgeon "just not feeling like operating in the evening," a problem that made RVU generation impossible. This was not an example of Reese being lazy or coddling his staff, but of relieving the hard charging Ngo of two small surgeries which Reese could perform the following day during the OR time vacated by a complex case that had been cancelled.

Arnold's investigation of the issues related to leadership in urology was superficial. (*Jurupa Unified School District* (2015) PERB Decision No. 2450-E, p. 22-23.) Whatever issues were reported to him by Russell and Siegel, Arnold never took the opportunity to discuss them with Reese. Arnold's citation of the radiation oncology complaint was irrelevant. That physician did not complain about Reese's leadership, but only expressed a desire not to continue seeing patients she felt were more appropriately seen in urology.

Unlike the leadership change he initiated in ophthalmology prompted by the Stanford department complaint about patient access issues, lack of supervision, unaccounted for time and patient complaints, Arnold cited no such external or internal complaints about urology. Reese's assertion that urology was one of the favored rotations for Stanford residents was unrebutted. The County cites the installation of a medical director in ophthalmology, where no VPG activist was present, and the lack of reprisals against other VPG officers holding chief or chair positions. The argument is unconvincing. The attempt to compare the installation of medical directors in other departments is largely irrelevant because Arnold's first choice was to install Ngo as the new chief – a decision made long before he settled on medical director as a way to parry Adams's foil. The installation of medical directors in other programs and departments, like primary care and hospital medicine, is explained by the size and complexity of the operational challenges in those areas, as distinguished from a five-person subspecialty.

Urology was a small operation and Reese did not need supplemental assistance to address operational issues. The retention of other VPG affiliated chiefs/chairs is explained by the fact that only urology presented an opportunity for Arnold to extend his authority, given the build-up of its backlog caused by his own delayed response to the staffing shortage.

Arnold claimed to rely on data reports, but cited no such reports of misuse of administrative time, time that was not accounted for, or lack of coverage of clinic time within urology. Adams failed to corroborate Arnold's clam that he brought clinic schedule, OR use, and RVU data to Adams's attention. The County's justification for removing Reese's duties was exaggerated and not supported by credible evidence of deficiencies on Reese's part or failed attempts to correct deficiencies brought to his attention. (*Sacramento City Unified School District* (2010) PERB Decision No. 2129-E, p. 32.)

Arnold stated to Adams that Ngo's immediate appointment as medical director was necessary because of the urgency of achieving the Triple Aim and improving access. Arnold contended that increased access was necessary for sustainability of the SCVHHS in an "increasingly competitive and disciplined external environment" where other private entities are seeking to enroll Medi-Cal patients. This claim is highly exaggerated. (*Coachella Valley Mosquito and Vector Control District* (2009) PERB Decision No. 2031-M, pp. 18-19.) SCVMC is a state safety net provider. The legislative scheme protects the County against private sector competition. The County system has a captive market of Medi-Cal patients, is protected by more favorable Medi-Cal reimbursement rates than private sector providers, and has seen the conversion of many of its previously uninsured patients to insured status as a result of the

PPACA.[24] The hospital administration's seeming acquiescence in the grand jury insistence on financial self-sufficiency is inconsistent with its legal obligation under Welfare and Institutions Code section 17000. Ngo failed to demonstrate the ability to implement changes in urology that reduced the time needed to complete surgical procedures, clinic encounters, or teaching activities. Nor did he demonstrate the ability to change the patient mix from non-reimbursable to reimbursable, aside from demanding higher RVU production.

There were other inconsistencies in Arnold's justification. Arnold desired physicians who improved efficiency by being multi-skilled and practicing at the top of their license. Due to his lack of experience, Ngo did not fit this profile. (*Coast Community College District* (2003) PERB Decision No. 1560, adopting adm. law judge's decision at pp. 36-37.) Arnold favored team leaders, but Ngo did not fit that mold, as revealed in Adams's assessment of the division morale. The team approach to health care reform relates to reassigning duties performed by

[24] The County has a "two-plan" system for Medi-Cal enrollees which limits them to choosing between a county-organized local initiative plan (Santa Clara Family Health Plan) and a private plan (Aetna Blue Cross). (2016-2017 Santa Clara County Civil Grand Jury Report, "You've Got Medi-Cal – But Can You Get Medical Care?," p. 2.) The 2013-2014 state budget provided financial protection to the County as a result of the impact of the PPACA, including provisions to guarantee that county public hospital systems achieve their target of newly eligible enrollees (e.g., being the default choice for enrollees failing to choose a managed care provider up to the system's primary care capacity), requiring county managed care plans to provide cost-based reimbursement to county public hospitals, and providing for capitation rate increases for all Medi-Cal recipients. (Welf. & Inst. Code, secs. 14199.1, 14199.2, 14305.1; Leg. Counsel's Digest, Assem. Bill No. 85 (2013-2014 sess.).) A 2015 county grand jury report found the County had been assigned 78 percent of the eligible Medi-Cal enrollees. (2016-2017 Santa Clara County Civil Grand Jury Report, *supra*, p. 2.) Reflecting a capacity issue not being met by the County alone, Medi-Cal enrollees were having difficulty finding a primary care doctor willing to treat them, leading to use of high-cost emergency rooms for out-patient services. (*Id.* at p. 5, 7.) Unlike private sector providers, the County is eligible for federal disproportionate share hospital funding as a county hospital serving significant numbers of low-income uninsured and Medi-Cal patients. (California Health Care Foundation, "Locally Source: The Crucial Role of Counties in the Health of Californians," Oct. 2015, pp. 11-12, 17-18.)

highly compensated physicians to lower paid members of the care team. Ngo offered no evidence he brought ideas on how to implement this goal in urology. Arnold allowed urology to be understaffed long enough that a patient safety issue was actually created in June 2014 when Reese began dozing during clinic time.

Arnold deviated from the custom and practice regarding appointment of division chiefs. Dr. Nguyen testified that chief appointments have traditionally been given on the basis of merit and seniority, and decisions are arrived at with consensus of all parties. (*Santa Clara Unified School District* (1979) PERB Decision No. 104, p. 15.) Adams objected to Arnold's proposal in March to appoint Ngo as chief. Not the least of his reasons was Ngo's lack of board certification, which violated the department rules. Arnold eventually appointed Ngo to be a medical director, but that occurred only after he was repeatedly foiled by Adams. Nothing in the record rebuts or explains Arnold's delayed response to Reese's proposal on staffing, his rejection of Reese's requests for a meeting to discuss his idea for leadership change in urology, or Adams's advice to Reese to cease contact with Arnold for fear of adverse consequences.

The County disputes the existence of any evidence of personal conduct on Arnold's part suggesting unlawful animus. It cites Reese's inability to identify any contentious exchanges with Arnold at the bargaining table or meetings of the implementation committee. The County contends no inference of animus should be drawn Arnold's failure to inform Reese that his operational duties were being removed because Reese established no evidence of a practice or policy of providing justifications for a decision. (See *City of Alhambra* (2011) PERB Decision No. 2161-M.) It rejects the notion that the "boundaries" email is reflective of animus.

The argument is unconvincing. Although Reese acknowledged he was open to leadership transition in 2013, Arnold never proposed Ngo's ascension to Reese and kept Reese in

the dark about matters related to his recruitment, hire, and elevation, while adopting the weak justification that Adams was cooperating in the transition when he was not, and claiming to rely on Adams to implement his vision of efficiency within the department. Referring Reese to the finance department without engaging him on the staffing proposal, or endorsing his request, was a subtle way of putting Reese off. The refusal to agree to gender wage parity for Dr. Harris was another example of Arnold waving Reese off. Reese was the better "team player" in this instance. Arnold did not dispute Adams's opinion that by March 2015 Reese had gotten under his skin. Arnold's "boundaries" email likely reflects his frustration in establishing the authority necessary to implement his objectives in the face of opposition from both the medical staff and VPG. This is typical for a chief medical officer with no natural constituency, unlike those groups. Adams denied even discussing the issue of boundaries with Arnold.

City of Alhambra involved a failure to explain a rejection on probation where the employer is not legally required to give a reason. The probative value of Arnold's interactions with Reese is that he developed a pattern of avoiding Reese's invitations for meetings and conveyed his dislike of Reese to Adams notwithstanding the lack of contact. Arnold could only recall two issues he raised with Reese, none of which involved his alleged deficiencies as a division leader. (*State of California (Department of Parks and Recreation)* (1983) PERB Decision No. 328-S, p. 12.)

For all the foregoing reasons, Dr. Reese has established that the County's removal of his administrative duties as chief of urology was an adverse action imposed because of his protected activity, in violation of MMBA sections 3506 and 3606.5 and PERB Regulation 32603(a).

REMEDY

Pursuant to section 3509, subdivision (a), the PERB, under section 3541.3, subdivision (i), is empowered to order remedies necessary to effectuate the policies of the Act.

The County has been found to have violated sections 3506 and 3506.5 and PERB Regulation 32603(a) as a result of discriminating against Dr. Reese by removing duties from his role as chief of urology at the SCVMC. The appropriate remedy is to cease and desist from such unlawful conduct. (*Rio Hondo Community College District* (1983) PERB Decision No. 292.) Further, the County is ordered to restore the status quo ante by reinstating Reese to the position of chief as it existed prior to September 1, 2015, including restoration of all duties transferred to the medical director of the division. (*Rainbow Municipal Water District* (2004) PERB Decision No. 1676-M.)

In addition, it is the ordinary remedy in PERB cases that the party found to have committed an unfair practice be ordered to post a notice incorporating the terms of the order. Such an order is granted to provide employees with a notice signed by an authorized agent that the offending party has acted unlawfully, is being required to cease and desist from its unlawful activity, and will comply with the order. Thus, it is appropriate to order the County to post a notice incorporating the terms of the order herein at its buildings, offices, and other facilities where notices to bargaining unit employees are customarily posted. Posting of such notice effectuates the purposes of the MMBA that employees are informed of the resolution of this matter and the County's readiness to comply with the ordered remedy.

PROPOSED ORDER

Upon the foregoing findings of fact and conclusions of law, and the entire record in this case, it has been found that the County of Santa Clara (County) violated the Meyers-Milias-Brown Act (MMBA) in case number SF-CE-1329-M as a result of discriminating against Dr. Jeffrey Reese in violation of Government Code sections 3506 and 3506.5 and Public Employment Relations Board (PERB or Board) Regulation 32603, subdivision (a) (Cal. Code of Regs., tit. 8, sec. 31001 et seq.).

Pursuant to section 3509, subdivision (a), of the Government Code, it hereby is ORDERED that the County, its governing board, and its representatives shall:

A. CEASE AND DESIST FROM:

1. Discriminating against Dr. Jeffrey Reese because of his activities on behalf of the Valley Physicians Group.

B. TAKE THE FOLLOWING AFFIRMATIVE ACTIONS DESIGNED TO EFFECTUATE THE POLICIES OF THE ACT:

1. Restore Dr. Reese to his position as chief of the urology division in the surgery department as it existed prior to September 1, 2015, including all duties transferred to the medical director of the division.

2. Within 10 workdays of the service of a final decision in this matter, post copies of the Notice, attached hereto as an appendix, at all work locations where notices to employees in the certificated bargaining unit customarily are posted. The Notice must be signed by an authorized agent of the County, indicating that it will comply with the terms of this Order. Such posting shall be maintained for a period of 30 consecutive workdays. Reasonable steps shall be taken to ensure that the Notice is not reduced in size, altered, defaced

or covered with any other material. The Notice shall also posted by electronic message, intranet, internet site, and other electronic means customarily used by the County to communicate with employees in the certificated bargaining unit.

3. Within thirty (30) workdays of service of a final decision in this matter, notify the General Counsel of PERB, or his or her designee, in writing of the steps taken to comply with the terms of this Order. Continue to report in writing to the General Counsel, or his or her designee, periodically thereafter as directed. All reports regarding compliance with this Order shall be served concurrently on the charging party.

Pursuant to California Code of Regulations, title 8, section 32305, this Proposed Decision and Order shall become final unless a party files a statement of exceptions with the Board itself within 20 days of service of this Decision. The Board's address is:

Public Employment Relations Board
Attention: Appeals Assistant
1031 18th Street
Sacramento, CA 95811-4124
(916) 322-8231
FAX: (916) 327-7960
E-FILE: PERBe-file.Appeals@perb.ca.gov

In accordance with PERB regulations, the statement of exceptions should identify by page citation or exhibit number the portions of the record, if any, relied upon for such exceptions. (Cal. Code Regs., tit. 8, § 32300.)

A document is considered "filed" when actually received during a regular PERB business day. (Cal. Code Regs., tit. 8, §§ 32135, subd. (a) and 32130; see also Gov. Code, § 11020, subd. (a).) A document is also considered "filed" when received by facsimile transmission before the close of business together with a Facsimile Transmission Cover Sheet or received by electronic mail before the close of business, which meets the requirements of PERB Regulation 32135(d),

provided the filing party also places the original, together with the required number of copies and proof of service, in the U.S. mail. (Cal. Code Regs., tit. 8, § 32135, subds. (b), (c) and (d); see also Cal. Code Regs., tit. 8, §§ 32090, 32091 and 32130.) Any statement of exceptions and supporting brief must be served concurrently with its filing upon each party to this proceeding. Proof of service shall accompany each copy served on a party or filed with the Board itself. (See Cal. Code Regs., tit. 8, §§ 32300, 32305, 32140, and 32135, subd. (c).)